

**O & P Services Inc.**  
**FINANCIAL TERMS AND AGREEMENT**

Clients Name: \_\_\_\_\_

Chart # \_\_\_\_\_

This Financial Agreement serves as a binding contract between O & P Services Inc. and the patient/Guardian/client.

By Signing the consent to Treat and this Financial Agreement. I Hereby request that O & P Services Inc. Provide the necessary **Custom-Made Device** as prescribed by my physician and assume full financial responsibility for payment of same. I hereby agree to pay any balance on my/my child's account that is not covered by my insurance, Medicaid, Medicare and or CSHCN Benefits. Delinquent accounts will be reported to the credit bureau.

**I certify that** my current insurance coverage;

Name of Insurance 1 \_\_\_\_\_

Name of Insurance 2 \_\_\_\_\_

Name of Insurance 3 \_\_\_\_\_

\_\_\_\_\_ 1. Devices provided by O & P Services Inc. are custom made. If within seven days of evaluation I/we decide that we do not want the custom devices, as prescribed by my physician, I will notify O & P Services Inc. in writing. Notice to be mailed to

O & P Services Inc. 1440 Regal Row #230, Dallas Tx 75247

\_\_\_\_\_ 2. Patient's portion payment or services is due on date of delivery. Medicare patients will owe 20% if they do not have secondary coverage. Private Insurance patients will owe the balance of the annual deductible and co-insurance amount.

\_\_\_\_\_ 3. If I fail to show for my appointment for delivery of the device, I understand that I am still financially responsible for the cost of the device. I understand that my insurance company will be billed and any balance due will be my responsibility.

\_\_\_\_\_ 4. **By initialing each of the above, I confirm that I understand that my financial responsibility and agree to abide by these terms. I confirm that I have received a copy of the form.**

**APPROVED HIPAA CONTACTS**

If you would like to add additional contacts (other than the patient or legal guardian) that O & P Services Inc. is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition please choose the person you would like O & P Services Inc. to list as your emergency contact in the event of an emergency situation in our office.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Billing Account Information       Medical Condition Information       Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Billing Account Information       Medical Condition Information       Emergency Contact

Medicare Patients Only: Have you received any Prosthetic/Orthotic devices within the last 5 years?

Yes     No      If yes, Date Received \_\_\_\_\_ Type of Device(s) \_\_\_\_\_

\_\_\_\_\_  
Patient/Legal Guardian

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date